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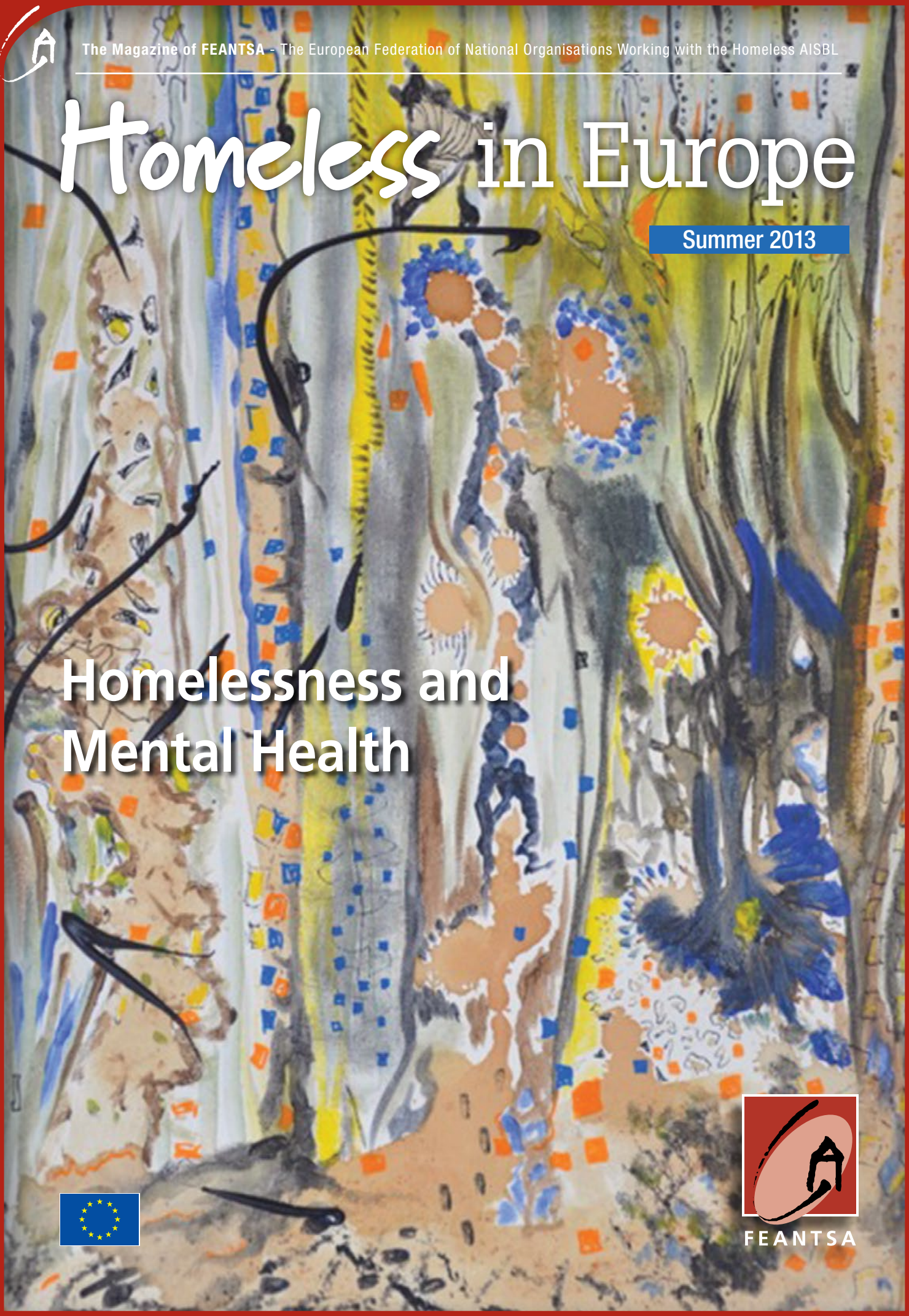

Homelessness and Mental Health

FEANTSA

IN THIS ISSUE

Homelessness and Mental Health

by **Dalma Fabian,**[1] *FEANTSA Health and Social Protection Policy Officer*

How we think of mental health is very much shaped by our disciplinary affiliation: whether we are doctors, psychologists, sociologists or social workers. This is clearly reflected in the diverse terminology used in the field. For instance, psychiatry - in line with the medical approach - uses the term 'mental illness' or 'mental disorder', while social workers are more likely to opt for 'mental health problems' or 'mental distress'. While each of these professions often claims authority over what constitutes mental health and illness, these seemingly separate perspectives can be integrated into a wider understanding of mental health. The so-called *biopsychosocial* approach that incorporates the biological, psychological and social models of mental health takes into account the interaction of social structure and personal agency.

Much has been written on the interrelatedness of mental health and homelessness, some arguing that mental health problems lead to homelessness, while others claiming that homelessness is a stress factor which provokes ill mental health. Although the direction of causality is not straightforward, the link clearly shows how mental health cannot be treated in isolation and how its wider social context, e.g. social status, poverty or social relations, has to be considered. We have to acknowledge the enormous impact that the social conditions in which we are born, grow up, live, work and grow older have on our mental health. The effects of the social determinants of mental health, such as early childhood development, social safety network and housing are long-lasting, but, if improved, can result in better health outcomes for many.

Mental health problems affect homeless people disproportionately. Research shows that the more severe the level of homelessness, the poorer the level of mental health. Yet, less than one-third of homeless people with mental health problems receive treatment. Lack of coordination among services and the difficulties homeless people face in obtaining health insurance are identified as major barriers to accessing services. What also often stands in the way of receiving much-needed health and social care is stigma. Homeless people and people with mental health conditions are among the most stigmatised populations in our societies. Stigma is conceptualised as a process. It begins when dominant groups distinguish human differences - whether or not these are real. Collective notions are used to categorise a group of people, usually according to negative ideas and stereotypes. Prejudice occurs when these negative ideas, such as homeless people being 'crazy', 'dirty' and 'lazy', turn into attitudes. The culmination of the stigma process is when attitudes generate behavioural responses and emotions, e.g. discrimination and social exclusion. These day-to-day manifestations of stigma harm and undermine people who are homeless and mentally ill, and as a result, they become isolated and demoralised, and develop what Goffman calls a 'spoiled identity'. This is the case when stigma becomes internalised and this self-stigma has a profound impact on the ability of the person to exit homelessness and recover from mental health problems.

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LETTERS TO THE EDITOR

We would like to give you the chance to comment on any of the articles which have appeared in this issue. If you would like to share your ideas, thoughts and feedback, please send an email to the editor, suzannah.young@feantsa.org.

People who live on the margins of society, in addition to the hardship of homelessness, are further stigmatised by society in its effort to legitimise inequality by blaming the disadvantaged for their predicaments. Health and social care professionals who provide services for homeless people do not practise in a moral or political vacuum and are no less immune to prejudicial attitudes and behaviours. There is evidence suggesting a high level of stigma and maltreatment of homeless individuals by practitioners within the homeless sector. In order to improve health outcomes, stigma-reduction campaigns should be implemented together with education on mental and addictive disorders among workers. It is crucial that all professionals working in homelessness services have a full understanding of the current levels of need relating to mental health and well-being and know how to respond effectively. Homelessness services play a key role in promoting good mental health and well-being, as well as ensuring that if mental health becomes unmanageable for an individual, they can access the help and support they require in a timely way.

Lack of coordination between services also continues to be a significant barrier preventing homeless people from accessing services and often results in homeless people being passed between services. One example of how individuals can fall through the cracks of the system is the case of dual diagnosis, a common mental health issue relating to homelessness. Dual diagnosis refers to people who have both a diagnosed mental health illness and addiction issues. It is an area fraught with contention and diagnostic dilemmas for practitioners as it can refer to an individual with mental illness leading to substance misuse, or to substance use worsening or altering the course of mental disorder, dependency leading to psychological symptoms or substance use withdrawal leading to psychiatric symptoms. This issue is very prominent in the case of homeless people and yet there is a lack of a common approach that would enable tackling both their mental health needs and their problematic alcohol or drug use.

Alongside mental health and substance misuse, homeless people often have independent life events, such as loss, trauma or relationship breakdown, as well as issues linked to broader social problems – such as poverty and unemployment – that trigger homelessness. It is, therefore, essential to recognise that homelessness is usually part of a broader picture of multiple exclusion and disadvantage and this recognition should underpin policy and practice in mental health. A biopsychosocial approach that endorses the different perspectives of mental health and takes into consideration the complex and overlapping needs of homeless people can offer recovery-oriented, person-centred and holistic mental health services.

FEANTSA would like to thank all the authors who have contributed to this issue of the magazine.

Traumatic Brain Injury and Mental Health Amongst Individuals Who Are Homeless

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[S]tudies have reported rates of TBI ranging between 8%-53% amongst homeless populations.

"Unidentified traumatic brain injury is an unrecognized major source of social and vocational failure." Wayne A. Gordon[1]

Traumatic brain injury (TBI), defined as a "an alteration in brain function, or other evidence of brain pathology, caused by an external force",[2] is a leading cause of disability worldwide.[3] Globally, it is estimated that 10 million people will be affected by a TBI each year.[4] In Europe and the UK alone, the incidence rate of hospitalizations for TBI is estimated to be 235 per 100 000 each year.[5]

A TBI can be classified as mild, moderate or severe depending on the extent of damage to the brain.[2] The majority of those who suffer a moderate to severe brain injury experience severe impairments that can radically affect their mobility, self-care and ability to reintegrate into society.[6] However, persistent symptoms are not uncommon after mild TBI, affecting 10%-15% (a conservative estimate) of those injured.[7] The cognitive, physical and emotional consequences that follow TBI can include headaches, dizziness, fatigue, irritability, problems with memory, attention and concentration, and mental health issues such as depression and anxiety. These symptoms may become chronic and place individuals at risk for social failure. TBI also occurs more frequently among young persons and their deficits may compromise their prime working years.[3];[8]

Psychiatric problems such as depression, anxiety, post-traumatic stress disorder and substance abuse are common among people with TBI and may pose disruptive social and occupational consequences.[9-12] Substance abuse is considered both a risk factor for and outcome associated with TBI: pre-injury rates of substance abuse are higher than those in the general population, and post-injury are estimated to be as high as 50%.[13] Major depressive disorder appears to be the most common mental health problem for those with a TBI, with an estimated prevalence of 61% within the first seven years post-injury.[12] Nearly a quarter of TBI patients are estimated to have generalized anxiety disorder and data show that 16.5% of those with TBI meet the criteria for post-traumatic stress disorder.[9] There is a general consensus in the literature that TBI puts individuals at an elevated risk for mental illness and that some psychiatric problems following a brain injury may be associated with worse global outcomes and diminished social functioning.[12]

"Unfortunately the psychiatric impairments caused by TBI often go unrecognized [in homeless populations]." -- Silver and Felix (1999)[14]

Very little is known regarding rates and significance of past TBIs upon the functional, vocational, and health-related status of individuals who are homeless, and even less is known about the inter-relationship between TBI and mental health concerns amongst this population. In a recently published systematic review article,[15] we were able to find only eight studies in the scientific literature which have explored the rates of TBI amongst individuals who are homeless. One additional article has since been published.[16] These studies have reported rates of TBI ranging between 8%-53% amongst homeless populations. Seven of the studies included measures of mental health status.[16-22] Mental health was assessed in these studies using Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria,[16];[17];[22] validated mental health screening measures such as the Addiction Severity Index and SF-12 Health Survey,[20] Brief Psychiatric Rating Scale,[22] or other patient questionnaires.[18];[19];[21] As summarized in Table 1, rates of mental illness varied widely across the studies, likely as a result of differing study populations and assessment approaches.

Only three of the seven studies which included a measure of mental health status explicitly looked at the relationship between past brain injuries and mental health.[16];[20];[21] In the largest study, Hwang and colleagues[20] found that 38% of their 904 homeless study participants reported "mental health problems in the last 30 days", with those who had a history of TBI being more likely to report mental health problems (33% without TBI versus 44% with TBI; $p<0.001$). Participants with a history of TBI also had poorer mental health component scores on the SF-12 Health Survey.[20] Hux and colleagues[21] screened for TBI amongst 1,999 individuals from four vulnerable groups, including 240 participants from a homeless shelter. Although the data were not separately reported for the homeless shelter group, across all participants, those with a positive screen for TBI versus those with a negative screen (despite one potential TBI incident) were more likely to report depression (63.38% versus 5.69%) and anxiety (47.82% versus 4.11%).[21] In a retrospective review of emergency department records, Svoboda and Ramsey[16] found that TBI rates were higher amongst

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chronically homeless people with drinking problems (46%) as compared to the general homeless group (15%) or those with low house-hold income (12%). Twenty percent of the chronically homeless, alcohol dependent cases and 15% of the general homeless group had co-morbid mental illness.[16] Interestingly, while having a previous head injury, drug dependence or a seizure disorder were predictive of having sustained a head injury in the previous year, depression and anxiety were found to be protective factors. The reason for this finding is unclear.

Aside from these few studies, there is very little empirical data available regarding the inter-relationship of homelessness, TBI, and mental health status or outcomes. Moreover, there are no data available which we could find examining these issues amongst homeless or at-risk youth. This is critical as studies have shown that in most cases (70%-90%), the first incidence of TBI precedes the onset of homelessness.[20];[23] Thus, early identification and management of symptoms amongst these youth may help to divert new cases of homelessness or the propagation of this status to chronic homelessness. Future studies should also examine different sex-based, cultural, and age-related factors.

Although our evidence base in this area is limited, there are strategies, which have been shown to be effective for individuals following TBI, which might be effective with individuals who are homeless. It is possible, that by addressing some of the symptoms of TBI, improvements in mental health status could be attained. For example, cognitive rehabilitation (e.g. memory training) has been shown to have positive outcomes on depression amongst survivors of TBI.[24] A group approach to anger management has been shown to be effective in individuals with severe TBI.[25] Physical post-concussive symptoms such as headaches and sleep difficulties have been associated with depression and irritability,[26] thus treatment of these physical symptoms may help to alleviate the mental health ones.

Sustaining a TBI can result in devastating consequences which could trigger an eventual downward spiral into homelessness. We recognize that homelessness is a complex phenomenon, with a myriad of contributing factors. However, we, as others, propose that the identification of a history of TBI may help to shed some light on these complex issues. If little else, perhaps recognition of a past brain injury may aide in the understanding of cognitive, behavioural, and mental health issues for both the individual who is homeless and for those caring for them.

Table 1. Summary of studies exploring TBI and mental health amongst homeless populations

ARTICLE	WHAT WAS THE STUDY SAMPLE?	HOW WAS MENTAL HEALTH ASSESSED?	HOW WAS HISTORY OF TBI ASSESSED?	WHAT WAS FOUND?		WAS MENTAL HEALTH LINKED TO TBI?
				RATE OF TBI	OVERALL RATE OF MENTAL ILLNESS	
Bremner et al. (1996)	62 men in a hostel program (London, UK)	Diagnostic interviews using the DSM-III-R	Self-report; defined as "sufficient to lose consciousness at some point in their life"	46%	17.7% schizophrenia; 6.5% major depressive disorder	Association not examined
Cotman and Sandman (1997)	24 men and women in an 18 month residential program (Orange County, California, USA)	Self- reported health history	Self-report (not defined)	8%	8% history of treatment; 79% former substance abusers; 67% reported drug abuse ; 42% reported alcohol abuse	Association not examined
Gonzalez et al. (2001)	60 men and women at a clinic for the homeless (Miami, Florida, USA)	Semi-structured interview using DSM-IV; Brief Psychiatric Rating Scale	Documented concussion or loss of consciousness, or patient's self-report of a loss of consciousness or serious blow to the head	38%	70% with non-psychotic conditions, major depression most common; 20% past alcohol abuse, 47% past poly-substance abuse	No, but reported that a psychiatric diagnosis or substance abuse history had no effect on neuro-psychological test performance
Solliday-McRoy et al. (2004)	90 men at a shelter (Milwaukee, Wisconsin, USA)	Self- reported health history	Self-report questionnaire	48%	50% history of treatment: 28% mood disorders; 8% psychotic disorders; 7% substance disorders; 4% anxiety	Association not examined
Hwang et al. (2008)	904 men and women at shelters and meal program (Toronto, Ontario, Canada)	Addiction Severity Index; SF-12 Health Survey mental component subscale	Self-report: "Have you ever had an injury to the head which knocked you out or at least left you dazed, confused or disoriented?"	53%	38% mental health, 42% alcohol, 57% drug "problems in the last 30 days"; mean SF-36 mental component subscale score was 41.3	Yes. TBI history linked with higher rate of mental health (43% versus 33%), drug (57% versus 40%) and alcohol problems (42% versus 28%); poorer mental health (SF-12 mean score 39.0 versus 43.8)

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Hux et al. (2009)	240 men and women at a shelter (Midwest state, USA)	Response to "P" from HELPS Tool: Problems in daily life since you hit your head?	HELPS Screening Tool, asks five questions about TBI events and any associated aftermaths	20%	Not reported	Yes. Those with positive screen more likely to have depression (63.4% versus 5.7%), anxiety (47.8% versus 4.1%)
Svoboda and Ramsey (2013)	All men: 50 CHDP; 60 GH; 59 LIH	Validated instruments for DSM III Criteria	Retrospective review of emergency department medical records	46% (CHDP) 15% (GH) 12% (LIH)	20% of CHDP and 15% of GH had mental illness	Yes. Having depression or anxiety was protective against subsequent TBI

CHDP, chronically homeless with drinking problems; DSM, Diagnostic and Statistical Manual of Mental Disorders; GH, generally homeless; LIH, low-income housed; TBI, traumatic brain injury.

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The Human Reality of Mortgage Evictions from a Multidisciplinary Perspective

By **Juan Ramis-Pujol**, *Ph.D.*,[1] *Department of Operations Management and Innovation, ESADE Business School, Ramon Llull University, Spain*

The basic objective of this study was to generate knowledge rooted in the reality of those persons who are evicted or in the process of being evicted in a mortgage-related case. We developed a multidisciplinary perspective based on the fields of economics, management, sociology and psychology. The methodological approach based on case studies was fundamental to solving the contradictions that appear between different disciplines and, therefore, to generating new and different knowledge about the phenomenon studied. Here we present a summary of the original paper.[2]

The main questions that we tried to answer through this research were the following:

1) What is the process experienced by victims of a mortgage-related eviction like?
2) How and why do the emotions and feelings noted develop during the eviction process?
3) How, in detail, do the victims experience this process?
4) How do the agents in the environment help the victims during the process?
5) What impacts are observed at the end of the process?

We structure this article by following five blocks of results corresponding to these five questions. Finally, in section 6), we present some proposals for action derived from the results.

WHAT IS THE PROCESS FACED BY VICTIMS OF A MORTGAGE-RELATED EVICTION LIKE?

With respect to this first question, we have observed that this process is normally very long and very tough. Above all, it is very tough due to the emotional insecurity, the uncertainty and the economic hardship that it involves.

We have been able to make sense of data by defining four stages[3] that help us to understand what occurs in the overall process long before the eviction takes place. We have also identified some critical events that we have classified as triggering,[4] aggravating[5] and paralysing.[6]

In view of these stages and these events, it is possible to anticipate the process and put forward proactive measures that will enable the victims to manage the process better. We have marked the triggering critical events with an orange traffic light, indicating that some actions are already necessary. We have marked the aggravating critical events with a red traffic light to indicate that action is urgently required. The paralysing critical events normally require specialist help. We have marked them with a double red light.

Towards the end of the process, we can observe a clear contrast between those cases that end more or less well, and those others that end badly, normally without a home and/or with debt, in which the torment continues for the victims.

Employment appears as something that would enable victims to escape from this situation. Indeed, on many occasions it is the loss of employment that has caused the situation. Above all, the victims ask for work over and above food or any other type of help. However, the study suggests that not all jobs provide the solution in this respect. In an insecure emotional situation, precarious temporary jobs can prove to be harmful.

HOW AND WHY DO THE EMOTIONS AND FEELINGS NOTED DEVELOP DURING THE EVICTION PROCESS?

The emotions appear in association with certain specific events. In the study we have identified the emotions that are most closely related to different events that are typical during the process: Fear, disgust, rage and crying.[7] We have also identified which emotions appear with the specific events that are directly related with banks, eviction itself, the world of work and other related matters.[8]

The representation of these emotions over time by means of the time graphs compiled shows a genuine rollercoaster of emotions. These emotions are unexpected, alternating and very intense, especially the negative emotions.

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2 The original paper and a related philosophical essay inspired by this topic can be downloaded at: www.fiayc.org

3 Four stages: 1- Beginning of the process; 2- Problems aggravate; 3- Eviction; 4- Post-eviction.

4 Triggering events are situated in the first stage. Some examples of triggering events are: Increased mortgage payments, first sick leave, marital separation, decrease in business turnover, etc.

5 Aggravating events are situated in the second stage. Examples of aggravating events are: Loss of job, serious illness, continuous precarious employment, etc.

6 Paralysing events can occur already in the second stage, most likely in the third stage, and also during the fourth stage. Examples of paralysing events are: inability to pay, bank harassment, letters from the court, no fixed address or homelessness, etc.

7 Other relatively important emotions recorded are: surprise, amazement and dread.

8 For instance the threats with very short deadlines from banks have produced fear, terror, rage and crying; court summons have produced amazement, rage and crying; serious illnesses during the process have produced fear.

Compared with the emotions, the feelings are associated with different periods of time of greater length.[9] The analysis of both emotions and feelings shows that the emotional impacts on the victims are very considerable and they also last a long time. Their excessive duration leads to serious collateral impacts which need to be alleviated insofar as is possible, and specialist help for the victims is normally required.

HOW, IN DETAIL, DO THE VICTIMS EXPERIENCE THIS PROCESS?

With regard to this question, we provide a frame of reference in order to try and understand the victims' experience and suffering in the drawn-out process of eviction. This frame of reference takes account of emotions and feelings, the victims' capacity to create meaning, and the actions that they take during the process.

Firstly, the idea has emerged that the victims have great difficulties in making an early diagnosis in the process; thus, they find it difficult to take appropriate measures from the beginning of the process. Furthermore, we have found that even in the final stages, the victims are incapable of finding meaning in what has occurred. They do not find any meaning whatsoever in relation to the depth of the trauma that they have to go through.

We can observe that, during the process, the negative emotional episodes become increasingly intense. At first, the negative emotions make it difficult to create meaning, and so wrong decisions and actions may be taken.

When the pressure that the victims feel around them increases, above all when they stop paying their instalments, their emotional insecurity increases, and there is a very real risk of collapse. This situation is a genuine time-bomb.

In extreme situations, victims may even experience a double impact, a double collapse, which means their world comes crashing down. They no longer fit into the world, they switch off and they are incapable of leading a normal life. They need specialist help to recover that is similar to that for victims of post-traumatic stress disorder.

The analysis of both emotions and feelings shows that the emotional impacts on the victims are very considerable and they also last a long time. Their excessive duration leads to serious collateral impacts which need to be alleviated insofar as is possible.

HOW DO AGENTS IN THE ENVIRONMENT HELP THE VICTIMS DURING THE PROCESS?

To begin with, five social agents of relevance in the process have been identified: Family and immediate environment; business environment; 'companies' related to housing (including banks); government departments; and social organisations.

First of all, those who help in the process are pinpointed. Of particular importance here are the social organisations. To be specific: Caritas, the Red Cross and PAH (*Plataforma de Afectados por la Hipoteca* (Mortgage Victims Platform)). On occasions, the family and the immediate environment also offer help.

Victims usually contact these social organisations too late, normally when they are already in a state of collapse and when the family is in a desperate economic situation. Even so, once these organisations have intervened, benefits are rapidly observed. Simply by listening to them, informing them and also helping them, these organisations give victims the chance to breathe again, and this has at least two effects: 1) victims can begin to solve their problems once again, 2) it helps them to recover their dignity as people.

Secondly, there are the agents in the victim's environment who have an obstructive effect in the process. In this group we would include most government departments (justice, employment [INEM – Spanish job centre], health), as well as local government administration, public companies and organisations (training, start-up services, etc.), and finally, utilities (electricity, telephone, etc.).

What the members of this group have in common is that, due to the notable slowness and inefficiency with which they work, instead of helping the victims, they represent a considerable obstacle, often wasting victims' time.

Finally, we have included the banks as a third category. In this process, banks change and cause harm. While the victims continue to pay, everything tends to go well. As soon as they stop the payments, the ways in which the banks and the victims interact can be seen to change significantly. Below, we have listed some of the changes observed in banks which have been noted in the study:

9 Relatively more important feelings recorded during the process have been: sadness, guilt, dejection, suffering, grief, anxiety, bad moods, despair, hope, anguish, discouragement and melancholy.

- Increased pressure to pay (Interviews, calls made to victims' homes, etc.)
- Very short deadlines for producing certain documents or for taking certain decisions
- Poor advice
- Little or unclear information
- Humiliating conditions imposed (e.g. having to show tickets for flight back to country of origin as a condition for cancelling debt)

WHAT IMPACTS ARE OBSERVED AT THE END OF THE PROCESS?

The majority of the cases analysed show a high or even the maximum level of post-traumatic stress. Therefore, this is a phenomenon that has a brutal impact on victims.

With respect to specific impacts, the following are the most important:

- Reactions of fear and impotence
- Long-term effects
- Negative impact on personal, social or professional life
- Health problems
- Change in life priorities
- Victims see themselves as different persons
- Change in habits and routines

That is all for what concerns the results of the study. Having provided a concise response to the five research questions, we will proceed to comment on the proposed actions that we have developed.

PROPOSALS FOR ACTION

These proposals do not purport to be exhaustive; for the moment, they have not been developed in detail, and they only seek to throw a little light on the possible actions that could be initiated in order to alleviate the suffering entailed by these eviction processes.

It is important to situate the proposals for action in time. We will now consider some of the most important proposals, advising on when during the process it would be best to bear them in mind.

In the initial stage, it would be worthwhile if, at the time that the mortgage is signed, information were to be given about the possible risks, the events that an eviction process can trigger, and the possible action that can be taken to alleviate these problems. In the event that an initial problem appears, it is important to help families to make economic adjustments. It would be a good thing if the social organisations could give the families a helping hand at this point.

If the problems get worse, it would be essential for a mediation system to come to the fore. At that moment it is necessary to act quickly and forcefully, and the help of a third party is very important. At the same time, it is necessary to step up the personalised psychological assistance provided, since at this moment the risk of demoralisation is very high.

If the point is reached where an eviction is planned, we should be capable of treating each case separately. All the cases deserve to be analysed individually and, once again, the role of a mediator is key. In principle, a fair share of costs should be sought. And finally, steps should be taken to ensure that the negotiated solution is an honourable one.

Finally, the post-eviction period continues to be difficult, even in the event that the process has been closed in a dignified fashion. It is important to continue to support the evictees in order to help them recover both physically and emotionally.

Psychotherapy with Homeless People

By **Peter Cockersell**,[1] *Director Health and Recovery, St Mungo's, UK*

I think there is a difference between those who have chronic histories of homelessness or rough sleeping, who spend years on and off the streets, and those who transit through homelessness because of economic circumstances.

Homeless people come in all shapes and sizes, and from all walks of life, from up the road and across the world. They are men, women, transgender, they are young and old, they have children and they are children. Some spend a few weeks or months homeless, sleeping on friends' floors or sofas – sofa-surfers they're called in Britain, as if it was some kind of hobby or sport – and some sleep in ruined factories, or in squats, or in drug dealers' houses. Some sleep in the parks or on the streets, often when they've exhausted all the other places. Some stay on the streets for weeks, for months, for years. Some spend decades on the streets. More than 10 people sleep rough on the streets of London every day *for the first time ever*. Every day.

But even though it's not very easy to talk of 'homeless people', or even 'rough sleepers', as if they were a heterogeneous group, we can say something about 'many' or 'most'. Our surveys and research show that many of our clients had traumatic early childhoods - 47% experienced neglect/emotional abuse; 34% experienced the early loss of (a) parent(s) through abandonment, separation or divorce, 31% through death (including murder and suicide); 27% say they were sexually abused as children, and the true figure is probably higher. Our clients report high levels of parental alcoholism, drug use, and domestic violence. Most - >60% - use drugs or alcohol. Most - >60% - have mental health problems. Many – around 35% - have physical health, mental health and substance dependency problems.

I think there is a difference between those who have chronic histories of homelessness or rough sleeping, who spend years on and off the streets, and those who transit through homelessness because of economic circumstances, international displacement, or the disruption of a relationship. The latter often move through homelessness institutions quite quickly, taking advantage of the offered help, perhaps finding some training or employment, and then finding their way back into integration. Integration, or dis-integration, is for them largely social and circumstantial, and the way back into society is not such a long journey.

For the former, the 'chronic' homeless, it is not the same, and they are the ones for whom the 'most' and 'many' descriptors above are most true. For some of them, they have been homeless all their lives: they never had a 'home', a safe place where people loved them and cared for them. For some of them, even inside themselves was not a safe space, but somewhere full of conflicts, oppositions and impossible reconciliations. How do you make sense of the fact that you love your mother and she loves you, and she leaves you hungry and dirty and allows people to sexually abuse you? For some, dis-integration, or integration, is as much intrapsychic as social and circumstantial. They have experienced shattered and shattering lives, and their very selves feel shattered and fragmented.

We employ psychotherapists to work with homeless people because many of them have come through life experiences that are extremely difficult and damaging. Some have lifelong histories of abuse and neglect from family, statutory institutions, and 'friends'; many people I have worked with were abused as children, saw horrific violence towards their mothers, and were taken into institutional 'care' only to be abused again, started drinking and taking drugs, became violent towards their abusers and went to prison, and then started an adult life of streets, drugs and prison, interspersed with more abuse and not infrequent experiences of death and violence – this is what we call complex or compound trauma, and is at the root of most of the mental health problems we meet. Some have very traumatic 'one-off' experiences; one man I worked with went to work one day and his wife and two children were killed in a car accident while he was at work. He couldn't bring himself to go home again. He spent 25 years, mainly on the streets, before being able to accept what had happened.

The psychotherapists work with them on unconscious, emotional, cognitive and conscious processes around their experiences, as the clients bring them. Neuroscience suggests strongly that psychotherapy heals through interpersonal psychobiological regulation - through relationship essentially - which in turn changes the psychobiological capacities of the client, thereby effecting sustainable change. This demands resilience and the capacity for conscious processing of unconscious material in the mind of the psychotherapist. We employ fully qualified psychodynamic or psychoanalytic psychotherapists because they have had years of personal therapy as well as good clinical training, so we can be more confident that they can process the client's unconscious material rather than engage in an unhealthy unconscious emotional action/reaction sequence. The clinical and research evidence also supports the effectiveness of psychodynamic psychotherapy with people with borderline personality disorders, and with homeless people.

Homeless people, and rough sleepers in particular, are wonderful 'customers': if they don't think a service is useful for them, they simply don't engage and don't come. Around 70% of homeless people/rough sleepers take up therapy after their first session, and after that attendance is over 75%. Of those who are 'pre-contemplative' on the Cycle of Change before starting psychotherapy, and who take on therapy,

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100% move from Pre-contemplation to Action within a few months. In other words, those who don't care and won't engage, begin to care enough to start to make real changes in their lives. Evidence suggests that this process of self-motivated change, initiated by psychodynamic psychotherapy, continues long after the therapy itself is over.

Crucial to this level of engagement and impact is the way in which we deliver the psychotherapy. It is delivered where, and how, people can manage it. We do not simply run a clinic and tell people they must come at such and such a time or they will be excluded form the service. The therapists will meet people and work to engage them, will hold therapy sessions in all sorts of places – day centres, gardens, bedrooms, offices, day centres, hostels – wherever the client feels safe. One woman who used a day centre used to come in, lock herself in the toilet for a couple of hours, and then leave again, without engaging with anyone. The therapist first engaged her in the toilet, with the woman in the cubicle and the therapist in the washroom part. Gradually, they came to be able to meet in the washroom part. Now, the woman meets the therapist regularly in the therapy room for a pre-arranged appointment of a fixed time – and she also engages with housing and other services the day centre offers.

The therapists also work with people where they are psycho-emotionally, not with where we want them to be. Clients of the psychotherapy service do take drugs; they do drink alcohol; they smell; they have dogs (in the sessions – one little bull terrier has taken to sitting on the therapist's lap while she listens to, and talks with, his owner). They come, and they talk about what matters to them, and the therapist works with that, and with their relationship, using techniques from cognitive, transactional, psychodynamic, gestalt or whatever else seems helpful, and all within a psychodynamic framework. 'Being with' is important, and valued. Not taking notes is valued, 'properly confidential' as one client called it.

Outcomes include over 75% with improved wellbeing on a Wellbeing Impact Assessment Scale developed with the South London and Maudsley NHS mental health trust, improvements across the Outcomes Star domains,[2] and improvements in employment and training take-up, appropriate use of health services, reduction in emergency healthcare, and more positive housing outcomes. Our psychotherapy service with the '205' most 'entrenched' rough sleepers, for example, had an over 80% engagement rate and a 94% positive housing outcome for those engaged.

Psychotherapy works for rough sleepers, and particularly works for the chronic rough sleepers and long-term homeless with complex needs and backgrounds of complex trauma. Sadly it is not as widely available as we think it should be. We would like this to change. We are intending to publish a theoretical framework for psychotherapy for homeless people in autumn 2013, and to publish our model in spring 2014. We also hope to host a conference on clinical psychotherapeutic interventions with homeless people and rough sleepers in March 2014.

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2 http://www.outcomesstar.org.uk/

Was a Choice Ever Made?

By **Lotten Säfström**,[1] *Author and Lecturer*,[2] *Sweden*

My story is not a typical one but then, as you hopefully know, no one's story is. I had a very comfortable upbringing. We had nannies staying at our houses and people to run the day-to-day chores. My parents had successful careers and my siblings and I attended very good schools in several countries. My grades were high and I seemed to fit in well with developed social skills. 'Seemed to' being the operative words here.

From a very young age, my first memories actually, I felt like an outsider. I adapted easily thanks to my ability to read people but inside I didn't experience a feeling of belonging. I wasn't there. Never really there. I learned to act in the way that was expected of me but without actually reacting or truly interacting.

I was introduced to alcohol when I was five years old. A glass of wine mixed mostly with water and a sprinkling of sugar. The effect of the drug struck me immediately and I felt at home, more than I had ever known.

I was living in Saudi Arabia when I left my family at the age of fourteen to live at a boarding school in Sweden. There I could use alcohol more freely. It was my drug of choice throughout the forthcoming 25 years of addiction, 22 of which I spent as a homeless person.

In my early teens, I was still uncomfortable with connecting with others and using a drug became what I counted on for my wellbeing. The sense of belonging and relaxation I got from it was unparalleled.

Since I started living in sobriety in March 2006, I have heard many other recovering addicts describe the same experience, at whichever age their drug abuse started.

I began using alcohol excessively with kids my own age. Later, I smoked hash and, in time, used many other narcotics. They enabled me to take time out from alcohol which is an extremely potent, physically destructive and mind-altering drug. This potent solvent always held pole position in my choice of substance but it affected my physical state to the degree that I had to exchange it for a time at certain periods of my life. I used heroin for two years when the alcohol had burnt out my system, but not even that drug could compete with my drug of choice in the long run.

The use of narcotics introduced me to a way of making money by dealing to support my lifestyle and from the age of fifteen I rarely held down a job. My friends and I taught ourselves how to make money and we looked out for each other, creating our own norms and standards to defend our way of life. I was only a criminal in the eyes of a corrupt society. Judged by misled citizens. A victim. My addiction and criminal activities escalated and so my identity as an outsider was strengthened alongside my inability to interact with people.

When I was in my early twenties, I decided to leave the apartment I had been renting for a short time in down town Stockholm and I moved into a basement. My hard earned money could be better spent on other things (read "drugs") than rent.

As I have realised in later life, I had actually already been homeless for several years at that time since I had terminated my last contract as primary leaseholder at the age of seventeen.

Can I claim that this decision was a conscious one? Was I capable of rational thought?

What I called "making choices" during my active addiction is not how I define sane deliberation today. In the light of the world and through my new drug-free lenses I can see that in those days I merely acted on impulses. The strongest of them, the one that ruled out all other matters, was how to create opportunities to use, obtain and get more money to buy, mainly my drug of choice, alcohol.

My inability to relate to other people is a disorder that I began to see in myself after I started to recover from my drug abuse. My relationships had never been as important to me as drugs were - had they been I would have found a way to stop using. I believed that drugs helped me to live.

Coexisting with others is a foundation of being human. The pain I felt due to my inability to nurture relationships drove me to extreme lengths to acquire and use drugs. They helped subdue the subconscious part of me that yearned to belong.

To be able to stay in recovery I must of course stay unconditionally sober, also as a lifelong process stay in touch with others regularly. For me this doesn't come naturally. I need to work on my behaviour, my responsibilities and my relationships. All the time.

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It is hard work but I can honestly tell you – it is worth every minute! A difficult day today does not amount to a fraction of the hardships I went through out there.

The satisfaction I sought in drugs, the freedom I sought in homelessness and the joy my worn out soul cried for were never mine to keep whilst created by chemicals. Satisfaction, freedom and joy are mine today and only because I ruled out what I imagined would uphold those states - drugs.

An affliction that many homeless people I have met and lived with suffer from is this awful disease of addiction. In the sphere of homeless people, not everyone is an addict but well over half are. If we imagine those numbers in the context of any other group in society, the percentage would be staggering and unacceptable. With the homeless it is another matter.

We often see these outsiders under the influence of drugs, mostly alcohol, and it is broadly accepted that the problem lies in the drug itself. This is a common misconception. For me, the disposition of seeing myself as an outsider came first – it was not the drugs that drove me to exist apart from others.

However, having developed the habit, everything else was secondary. I lived only for prioritising and pulling myself together enough to be able to seize the next opportunity to get intoxicated. As long as drugs were present in my life nothing else, and I mean *nothing* else, mattered in the end. Not my child, my family, not food nor housing. Not even my life. The life-threatening situations I put myself in are something no sane person would do.

I would talk to my family or my social worker with an underlying convincing tone of agreement, of understanding the point of what these "normal" people understood as important issues in life, but I was playacting. Not always consciously or elaborately but it was still always playacting – I didn't have a clue about the things normal, healthy people value.

My distance from normality and sanity was unfathomable for those I talked to. I managed to talk and agree myself out of situations, often agreeing to being a hopeless case. There we have the ability to act and say what is expected of us. To dupe is a "talent" that is in the marrow of most drug abusers. For me, as most clean addicts I've listened to since I started living in sobriety, an almost instinctive and excessive capacity was used to refine this ability. Anything to get those people out of my face so I could go undisturbed back to my bottle.

My lifestyle told the only truth. That is the only failsafe, tell-tale sign to determine what is actually going on between the ears of a person who is abusing alcohol, pills or narcotics. With an addict, the only way to see if the person truly understands what is being discussed, what is essential, is when you see that person living it.

For as long as I live I will keep gaining new insights about the hows and whys of my ending up living as an addict and a homeless person. So that I don't seek companionship in substances again, a focus on self-awareness in relation to others is the most important thing on this journey.

As I touched on briefly above, no-one's story or issues are the same. That said, I am generally convinced that the issue of the outsider more often than not springs from that person's dysfunctional nature. I have reached this conclusion both through my own experience and what I've heard from the numerous homeless and ex-homeless people I have met.

I do not wish the mental state I was in during my earlier life on anyone. I never want to be that confused, isolated and ruthless person ever again. I had no sense of what being human meant. The richness in give and take between people, learning the love of self which in turn teaches me to love another, the regular meals are what fuels me now. I was absolutely clueless!

This journey has everything to do with me not relapsing. Everything! If I use any kind of drug or drug substitute again it will rekindle my sense of being one with my addiction and not with other people. It will start to take over my mind and the risk of me following the impulse to use again is overwhelmingly high and most probable. Then I will be on the streets again. It might take a week, a year or a decade but at the other end of that bottleneck I am sure I'll end up living, or more accurately existing, that way again.

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Those who suffer from the disease of addiction have a range of possibilities for coming to terms with their lifelong dissociative disorder. More so than those with any other mental health issue or life-threatening disease.

I use the twelve steps method[3] and there are numerous other ways to learn how to live a mentally manageable and rich life without the compulsion to use drugs.

The percentage of addicts being able to use any quantity or type of mind-altering substances and live a full life is vanishingly small, if it is at all possible.

I used to claim to suffer from all kinds of mental disorders and was believed by most professionals I met, but when I started to recover with zero-tolerance for any medication or drug, my mental state improved dramatically.

This has proven to be true for many addicts.

3 The Twelve Steps are guiding principles set down by Alcoholics Anonymous. More information can be found here: http://aa.org/pdf/products/p-42_abriefguidetoaa.pdf

My Freedom to Walk Away from Coercive Psychiatry

By **Jolijn Santegoeds**,[1] *Ex-homeless Activist against Forced Psychiatry and Founder of Mind Rights,*[2] *the Netherlands, Co-Chair of the World Network of Users and Survivors of Psychiatry*[3]

I left the mental health institution without a destination, and because the psychiatrist didn't support my leaving, I had no right to after-care. I was on my own, and I could go in any direction. I was free.

I was homeless for 2.5 years in the Netherlands when I was a young woman aged 19 to 21. Being homeless followed a period of forced institutionalisation in mental health care. To me, homelessness meant freedom and discovering life. It was the first time I could listen to my inner voice, and define my own path. It wasn't pure good or pure bad, but a combination of these, as it is in *'real life'*. Most of all, it was the way out of repression into freedom. Despite the fact that it wasn't all pretty out there, being homeless was a precious experience in my life - through it, I found my way.

MISERABLE IN PSYCHIATRY

Before becoming homeless, I was detained in a psychiatric institution for several years. This started at 16, when I had developed psychosocial problems. As an adolescent, I felt like I didn't fit in; I thought I was 'weird' and attempted suicide. Then I was involuntarily institutionalised in a young people's psychiatric hospital. They considered me 'severely dangerous to myself' and put me in solitary confinement 'for my own safety'. This was of course horrible, and it only made me more desperate. I still saw no way to live, and I kept trying to commit suicide. It became a daily struggle of escalations and repression. A downward spiral. This so-called 'mental health treatment' was not helping me. For nearly 2 years I was subjected to long-term solitary confinement, physical restraint and forced drugging. I experienced my life as a big struggle; I was fully repressed 'to prevent suicide', but that didn't stop me from feeling extremely suicidal. It only went from bad to worse. It was horrific. I saw no humanity. That is why I refer to those terrible years inside the mental health hospital as *'no life'*. The so-called 'treatment' was very harmful and traumatising.

I was lucky the ward got closed and I was transferred to an intensive-care psychiatric ward in another city. There I was treated more humanely, with more respect, and this meant a new start to my life. I was no longer fully restrained and repressed, and therefore I felt less threatened by the people surrounding me. I could finally open up to other things than resistance. It gave me a bit of hope that things could get better, while before I was convinced that my life was gone and I had felt stuck without any perspectives. The daily struggle gradually subsided, and I stopped fighting against my life. Then I came to a point where I recognised I could have a future.

FINDING MY SMILE

I remember the first time, after almost 3 years, I was allowed to go for a walk on my own. I didn't know where to go or what to do. Suddenly I was out in the world, and I had never felt so in control before. I wandered aimlessly around the psychiatric hospital grounds. And then I met some people from other wards. They invited me to join them, and smoke marijuana with them.[4] Although I was a bit scared, I agreed. We had fun and for the first time I felt great. They treated me fairly, as an equal, as a friend. We ate candy, played music and made efforts to look cool. I hadn't done those things for years and I loved it. It made me happy.

LEAVING WITHOUT SUPPORT

I went to see these friends every day. And all this fun made me forget my depressed and suicidal feelings. I really forgot about them, until the psychiatrist asked about it in a conversation about my frequent absence. I replied that my suicidal feelings had disappeared, and I wanted to leave. I wanted to live life. The psychiatrist said my treatment wasn't finished yet, and I had to stay. I refused and said there were no grounds to keep me locked in. I wrote a letter to the judge to ask to end the involuntary admission, because I was no longer suicidal. He granted me my freedom.

The fact that I was granted my request to leave without destination is unusual. In fact, in the Netherlands, it is very rare to succeed in such an appeal against involuntary placement. I considered myself very lucky. This was a unique chance I didn't want to waste.

In spring 1997, aged 19, I left the mental health institution without a destination, and because the psychiatrist didn't support my leaving, I had no right to after-care. I was on my own, and I could go in any direction. I was free.

FEAR OF HARM

From that moment I was homeless, but free. Yet, I was also scared and insecure. So many things had happened in my life that didn't make sense; I had been treated so badly by psychiatry, and I had had no rights. I had already experienced that nice words were no guarantee for good acts. It had confused me. I was afraid of the outside community, how they would judge me, and possibly harm me. I didn't understand

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2 www.mindrights.nl
3 www.wnusp.net
4 In Dutch law: Smoking marijuana (soft drugs) is not criminally sanctioned in the Netherlands. Marihuana can be sold legally in special shops.

how it worked and I wanted to avoid getting hurt again. I needed to observe and learn at a safe distance first. So I made sure nobody could come close to me.

HIDING IN A CUPBOARD

When I first became homeless I was sleeping in the bushes on the mental health institution grounds. I felt safe there, because it was the only place I knew, and I had some friends there. We still smoked together, and they often gave me food. We laughed a lot.

In the summer, the weather was good enough to sleep outside, but then autumn came and I needed shelter. A guy named Willem deliberately damaged a cupboard in the institution, so it was put in the garbage, where I could take it. I built my shelter out of that cupboard for sleeping at night. It looked like a miniature white house, with 3 walls and an orange plastic roof, hidden in the woods. It was my home for several months, and it shielded me from the harsh winter cold. Another homeless person, Peter, slept near my cupboard, and his smell kept everyone away, which made me feel safe. Only my friends knew where my place was. It was well hidden.

I felt like I had escaped, and I was finally in charge of my own life. I was satisfied, because I had my freedom. The rest was less important to me. I only cared about being out of the psychiatric institution.

HARD DRUGS

By then my group of friends had started using *speed* (amphetamines).[5] I was scared at first, but didn't want to 'wimp out'. Also, the psychiatric drugs I had been forced to take at the hospital actually formed the stepping stone to the illicit drugs. So I started using speed. I injected it to avoid side effects. Every morning, Peter and I took our first *shot* together near the cupboard. As a young woman, I wanted to keep control of myself and I needed to observe the world. So I just used small amounts to feel stronger, more confident and to stay awake, which felt 'safer' to me. It was a kind of self-medication.

I never committed a crime to get drugs. I had managed to secure welfare benefits by having a postal address, so I still had an income, which I managed well. I was terrified of getting into 'trouble with the system' again - any mistake would have cost me my freedom.

CHASED AWAY

Then I was banned from the mental health institution grounds. Several times the guards or police brought me to the city centre, where I didn't feel totally safe. I would walk back, and try to get onto the institution grounds again, looking for my friends. In the end I gave up and stayed in the city centre. Many of the friends from the institution I never saw again.

A SAFE DISTANCE

When I was homeless in the city centre, I was still afraid of people, so I kept my distance. I sat in parks during the day and I left when anyone approached me. I hid the fact that I was a girl, and appeared very dirty and smelly. Although I brushed my teeth every day and had clean underwear and socks, I made sure my outer clothes were dirty to keep people away.

In the city centre I was on my own, staying awake at night, cycling around to avoid contact. During the day, I tried to get some rest in parks and public places, where there was some social control and I would not be completely at risk. But I still feared people. I kept my distance, and continued to observe and learn.

NOT PART OF THE COMMUNITY

Back then, I didn't complain about my situation because I thought it was the only way out of the institution. To me, being homeless was the price I paid for my freedom, and this freedom was worth everything. I was proud of being strong enough to be able to survive on the streets. I already knew that 'care' could make it worse, so I still felt okay about being homeless. I knew where I came from, and I had a goal: to get a good life.

I felt different from 'normal people'. They were on the 'other side', and to me it felt like they were a different type of human, with a different destiny.

On the streets, I was stigmatised. People looked at me in disgust, disapproval and rejection. But I didn't care about their views. I knew why I was homeless. It was my choice to leave mental health care.

NIGHT SHELTERS

Eventually, I was able to get into government-run night shelters. There was a regular night-shelter for homeless people (non-addicts), which allowed one to stay for five nights a month for 7.50 guilders per night (now €7.50). At this shelter there were strict rules, such as: "no persons allowed from the mental health institution, and if anyone sees you drinking or smoking marijuana during the day you are not welcome anymore."

I had managed to get into the regular shelter several times, but then I found out that there was a special night-shelter for addicts which allowed one to stay for a whole month for free. All that was needed was a reference from the centre for addiction care. Having a place to sleep every night meant comfort, so I applied.

From autumn 1998 on, I frequently slept at the night-shelter for addicts for almost a year. Very often, I was the only woman there, which meant I had a 3-bed room to myself, and security in the corridor.

5 In Dutch law, possessing a small amount of hard drugs for personal use is not criminally sanctioned. Only selling hard drugs and possession of large amounts is criminally sanctioned.

ALLOWED TO EXIST

In the night shelter I was accepted by the other homeless drug users like part of their family. Some said: "If anyone ever hurts you, I will kick them". And although I dislike violence, this still somehow comforted me. I felt respected and safe. I never took up the offer, but feeling welcome, being included and their willingness to stand up for me was a huge thing in my life. It was the opposite of the institution, where they had violated me constantly.

Nevertheless, I continued living a solitary life amongst the hard-core multi-users, who were often using any drug to get as high as possible and could become aggressive, while I, on the other hand, was on a path of observation, discovery and personal growth. I didn't get involved in other homeless people's business. I just went my way, peacefully. And being allowed to do so, and not being punished, but still welcome and included, really gave me the feeling I had the right to exist. I was allowed to be there, and make my own choices. I could finally listen to my own inner motivations without being judged. I felt really free, and I felt like a human being.

MAKING MY OWN CHOICES

A lot of people didn't survive. Many 'disappeared'. Some were killed (murdered), some committed suicide, others died of accidental overdose and drug-related accidents. And so, fewer and fewer of them would return to the night shelter. I experienced these mainly as sad events which happened in this type of place. It wasn't particularly alarming, because in psychiatry there was also a high death rate, especially suicides. I had become used to the fact that many people 'on our side' die young. It was like a given which I had to deal with, as part of life. I was still paving my way through, and I was convinced that I wanted to survive by myself.

But then, it really got scary. There was a kind of 'gang-war' (5 killings in a row) and it involved some of the people from the shelter, but I didn't know exactly who it was and what happened. I had always avoided getting involved in these things. I didn't want to know. But it was also scary not knowing who was involved or not. Anyone could be a killer. I didn't want to have anything to do with any of them anymore. I was terrified. This was when I realised I had to get out of there. I didn't want to approach anyone for *speed* anymore, and I just quit using. I wanted a decent life. I hadn't run away from psychiatry for nothing.

'NO DRUGS, NO SHELTER'

I cycled through the city and the region every day, just to avoid meeting anyone, and to be away from everything. I hadn't told anyone I was *clean*. I didn't want to explain why, and neither did I want to lose my accommodation in the free night shelter. But after 2 months they found out I wasn't doing speed anymore and they kicked me out because I wasn't 'an addict'.

It was very ironic: for stopping doing drugs I was 'rewarded' by losing the right to access the shelter. This is a typical feature of rigid, offer-based care without a personal dimension. It reminded me of why I ran away from the institution, and I was convinced I had to make it on my own.

INVISIBLY HOMELESS

Many of the people I met when I was homeless had died by then, including Willem and Peter. I was going to a daily activity centre for persons with psychiatric/psychosocial backgrounds, where I made new friends. I no longer appeared dirty or neglected. I always carried my backpack with my sleeping bag and some clothes. It wasn't obvious I was homeless. I could have been a young (male) student or a tourist with a big bag.

I often hung around with friends from the activity centre. They came to the park or to the city centre after school, and we enjoyed ourselves. I looked forward to their company and no longer preferred to be alone. It was like the world got better every day. I was getting somewhere.

NO LONGER ALONE

I slept outside again, in parking lots, in parks, and near the central station. Sometimes friends stayed with me, watching stars, eating candy, having deep talks and a good time. These people became friends for life.

Ruben, a guy I knew, had become homeless too, and we kept each other company at night in the parking lot. The security guard even brought us coffee in the morning, after which we were supposed to go away. It was a wonderful time. I felt no longer alone and threatened, rather welcome, free and even a bit safe. It felt like camping in the city. I was happy.

THE WAY OUT

In October 1999, 'a friend of a friend' offered me a place to stay. For the first time I dared accept because he was an acquaintance and I believed he wouldn't harm me. It was a good choice, because it meant the end of homelessness.

LIFE RECOVERED

Several months later, in 2000, I started studying and in 2005 I graduated with a BA in Sustainable Engineering.

At the University of Applied Sciences, I became an activist against human rights violations. I have experienced many things that nobody should go through, and I want to stop these malpractices from happening. My main focus became to stop forced psychiatric interventions, which devastated me. Since 2003, I have been campaigning against forced psychiatric treatment[6] which is now my full time voluntary job.

6 www.mindrights.nl

In 2009, I was elected onto the board of the World Network of Users and Survivors of Psychiatry[7] of which I am co-chair today. I am also an active member of the European Network of Users and Survivors of Psychiatry.[8] I am active in international advocacy on mental health and the rights of persons with psychosocial disabilities.[9]

I have now been renting an apartment for about 12 years. I have a nice circle of friends with whom I have loads of fun. I enjoy my freedom, and I very much appreciate the many opportunities I have. I run my own foundation. I travel the world to promote and protect human rights in mental health care. I can actually turn my bad experiences into something good. All this makes me feel like a star. I have achieved a lot coming from 'nothing'.

FROM MISERY TO RECOVERY

I have mixed feelings about my homelessness. A lot happened that wasn't pretty. On the other hand, I had wished for freedom so often, and my wish came true, although I became homeless. Yet, it was my chance to be free and to grow, and I'm grateful for that.

Before becoming homeless I was treated very badly in the psychiatric hospital, where I was kept in solitary confinement for 2 years, often naked or in prison dress. When I was homeless, I enjoyed no longer being repressed and told what to do. I loved my freedom. I had clothes. I could move around. I could buy things to eat. I could enjoy the sun and nature, watching it grow, and think about my own growth, and how I'm part of nature too. Being homeless gave me time to listen to my inner voice, and find out what my heart said to me. I was no longer dominated by the terror of mental health care, and could finally shift from 'fighting against my life' towards 'defining my life'.

A HIGH PRICE FOR FREEDOM

Of course, instead of being homeless I would have preferred to have a safe place. And I did try to find somewhere to live during my 2.5 years of homelessness, however due to the bureaucratic system in the Netherlands, it was not possible.

Now I can see that I was only satisfied with this weird homeless life because I thought there was no alternative, no other way to get out of psychiatry and achieve freedom. Now I think it could have been different. My homelessness could have been prevented. My main wish back then was to have 'a life of my own. I didn't want care-interference in my life. I just needed a 'roof' and I had no high expectations. I should have been able to rent a room. But even despite the fact that I had an income and I was able to pay rent, finding a place to stay was out of reach for me. All services excluded me by their selection-procedures.

I should have had access to a rented room, just like any other young, independent person in the Netherlands. Having a room might have provided a shorter route to build my life. I had to develop myself in very tough circumstances, and I came through. I don't know what would have happened in more positive circumstances. However, as an ex-psychiatric patient, homeless person, and drug user I was stigmatised, and seemed not entitled to more positive circumstances. I had to survive on my own.

'NOT ENTITLED TO SUPPORT'?

I have no criminal record despite homelessness, mental health problems and drug use. The argument that the closure of institutions would make many people homeless and that it would result in increased prison-populations is therefore based on misperceptions.

If support in the community, such as housing, is made available, homelessness can be prevented. And also 'committing crimes' is often a result of marginal social chances, which can be prevented through support.

DESTINATION

Being homeless wasn't the worst thing that happened to me. The worst thing was forced psychiatry, where I was stuck in an endless struggle without dignity. In psychiatry, my life got worse every day. After that horrible experience, being homeless was an improvement. My life got better. My life perspective turned from going down to going up.

In the institution my life was meaningless; I had no social life. My choices were overruled, which made me powerless and unable to develop myself. I had no concept for my life or my future. Life was 'happening to me' and the situation was out of my control.

Then, once I was free, I could exercise decision-making and I became part of social dynamics, which made my choices meaningful as they had effects and defined my situation. I could start defining and developing myself, and grow into the person I am now. Having full decision-making power over my life was the most important part of my recovery. I reclaimed life by living it. I could finally find out how to do things my way, and that made me stronger. I paved my own way, and it brought me where I am now. I am proud of myself. Even though the road was tough, for me it was going upwards.

[A]s an ex-psychiatric patient, homeless person, and drug user I was stigmatised, and seemed not entitled to more positive circumstances. I had to survive on my own.

7 www.wnusp.net

8 www.enusp.org

9 The rights of persons with disabilities are gaining increased recognition internationally and are protected by the UN Convention on the Rights of Persons with Disabilities- an international treaty which the Netherlands has yet to ratify (it is only one of three EU states that has not yet ratified it).

The Value of Doing Things Right

By **Gabor Petri**,[1] *Human Rights Officer and* **Silvana Enculescu**,[2] *Communications Manager, Mental Health Europe*

For Mental Health Europe,[3] and indeed many other organisations working for or with (ex-)users of mental health services, deinstitutionalisation[4] is a clear goal. Mental health institutions have long been proven to perpetuate human rights abuses, and are decidedly ineffective. But closing an institution alone is not the answer as, if not managed properly, it can lead to homelessness and further distress. Any closing down of residential institutions must be coupled with the development of high-quality community-based services that are attentive to the needs of people with severe mental health problems and provide them with the support they require.

A TALE OF WIDESPREAD DESTITUTION

Institutions for people with mental health problems have many limitations that take their toll on the patients confined to them. Residents are isolated from the broader community and are forced to live together, they have insufficient control over their lives and over decisions which affect them, and the requirements of the organisation itself tend to take precedence over the residents' individual needs. Also, mental health institutions, as opposed to institutions for disabled people or for children, follow an overwhelmingly medical setup – admissions are based on previous medical examination and diagnoses and staff are medically trained or work under medical supervision.

Such institutions are still widespread in Europe, although the number of residents in "long-stay" residential facilities varies based on national and international statistics and the definitions employed. Mental Health Europe conducted a study in 2012 aiming to bring together data and information on this issue, which were consolidated in its "Mapping Exclusion" report. The report consists of a comparative analysis of existing trends and policies in Europe, along with 32 country reports[5] detailing issues important in the context of deinstitutionalisation and community living - numbers of institutions and community-based services, national deinstitutionalisation strategies or other relevant mental health strategies, information on personal budget schemes, guardianship and involuntary placement laws and policies. The research also focused on issues which are directly connected to the problem of institutional care, such as legal capacity, guardianship and involuntary admission and forced medical treatment.

Mental Health Europe reported that although most beds in psychiatric hospitals are for short-term, acute patients, many individuals with mental health problems live in such hospitals for much longer, often even for years. For example, 19% of the 27,900 patients in "public specialised psychiatric hospitals" (CHS) in France have been hospitalised between one and five years, and 23% have been hospitalised for over five years. In Malta, 43% of patients in psychiatric hospitals have been staying for five years or longer, and a further 14% between one and five years. Greece has around 660 long-stay patients in the five psychiatric hospitals that are still open following a major deinstitutionalisation programme in the 1980-1990s, and Belgium has over 13,000 long-stay psychiatric beds in psychiatric hospitals. In Bulgaria, it is estimated that approximately 30% of the patients in psychiatric hospitals live there for more than three years.

Psychiatric hospitals are not the only forms of institutionalisation for people with mental health problems. Social care institutions are also prevalent in many European countries, and these institutions are not run under the health care system of the given state, but as part of their social sector. In 2012, there were approximately 125,000 residents with mental health problems living in social care institutions in 14 countries. However, this number might be considerably higher, as social care institutions are often mixed provision – people with different disabilities can be accommodated in the same institution, which skews the statistics. This is particularly common in Central and Eastern Europe. In Hungary, the total number of places in social care institutions for people with mental health problems is 7,140, but some users of mental health services live in institutions for people with intellectual disabilities or in nursing homes for older people.

Although community-based residential support exists in most countries, in some cases it only reaches a small minority of people with mental health problems who use residential services. Thus, the number of people with mental health problems receiving support in the community is greater than the number of people in long-stay hospitals or institutions in 10 European countries, while in 18 countries more people live in institutional or long-term hospital settings than in the community (see map 1). For example, in Croatia, approximately 4,000 people live in social care institutions, while only 75 people use community-based,

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3 The present article is largely based on the publication "Mapping Exclusion," authored by Agnes Kozma and Gabor Petri. http://issuu.com/silvanamhe/docs/mapping_exclusion
4 The term is generally used as a reference to the process of moving away from institutional towards community-based care.
5 28 EU Member States (including Croatia which joined the EU in July 2013, Bosnia-Herzegovina, Moldova, Serbia and Israel)

organised housing. Or, in Moldova, there are only 17 places in community sheltered housing compared to 1,925 beds in long-stay psychiatric hospitals and 1,688 places in social care institutions.

It is important to bear in mind that a lot of the residents of mental health institutions are not there voluntarily. They have lost their legal capacity, and have thus been placed in the said institution by their legal guardians. Losing legal capacity means that the person concerned becomes unable to make legal decisions, such as signing a contract, filing a complaint, marrying, voting in elections, registering with their local authority, buying a property, or moving out of a residential institution. Plenary guardianship, where all decisions for the person concerned are made by a legally appointed guardian, is often called by human rights advocates as 'legal death'. Guardianship is an overwhelmingly important factor in the problem of institutionalisation, since it makes it impossible for residents of institutions to leave of their own free will, or to complain when becoming victims of neglect or abuse within the institution. Twenty-five of the 32 European countries covered by our report have guardianship regimes that implement plenary substitute decision-making. In most countries, both plenary and partial guardianship are possible, and in only two countries, Germany and Sweden, is only some form of partial guardianship used. However, despite the widespread guardianship systems, seven countries (Bulgaria, Czech Republic, Ireland, Latvia, Lithuania, Malta, Moldova, Slovakia) are currently introducing or planning to introduce new and, according to available information, more progressive legislation.

DEINSTITUTIONALISATION ON THE POLITICAL AGENDA

Since deinstitutionalisation has been recognised by many European countries as part of their social reforms, it is important to see which countries are reforming their mental health systems in line with those plans and which are not.

Sixteen European countries are currently implementing mental health strategies that identify deinstitutionalisation or the strengthening of community based-care as an objective (see map 2). For example, Belgium launched a major reform of mental health care, commonly known as article 107, in 2011. The reform aims to reduce the number of psychiatric beds by 10% and improve the organisation of care through the creation of care networks. In Finland, the national plan for mental health and substance abuse work for 2009-2015 – also known as the "Mieli" plan – foresees a 30% reduction in psychiatric hospital beds by 2015 and the expansion of the clubhouse network of mental health rehabilitation services to cover the whole country. Moldova has a National Programme on Mental Health for 2012-2016 that aims to reduce

MAP 1

Countries where the number of people with mental health problems receiving long-term support in the community is greater than the number of people in long-stay hospitals or institutions

Countries where the number of people with mental health problems receiving long-term support in the community is lower than the number of people in long-stay hospitals or institutions

Unknown

MAP 2

Countries which reported current mental health strategies identifying deinstitutionalisation or strengthening community based-care as an objective

the number of places in psychiatric hospitals and increase the availability of beds in general hospitals.

THE VALUE OF DOING THINGS RIGHT

There is no doubt that deinstitutionalisation can vastly improve outcomes for mental health service users. However, high-quality, community-based services must be developed at the same time, supporting those who have just left institutions. Otherwise, deinstitutionalisation can lead to severe exclusion and homelessness.

Deinstitutionalisation performed in a hurry or without proper preparatory work, often for financial or political reasons, is meaningless. Without a good service network of both mental-health specific and mainstream services that are open for mental health service users, all deinstitutionalisation means is sending people away from an institution to live in the community without help, without employment and often without a home to live in. As existing services for homeless people are often not prepared to have clients with severe mental health problems, such a mismanaged deinstitutionalisation process only exacerbates an already problematic situation.

Therefore, deinstitutionalisation must be complemented with adequate social investment that supports integrated and personalised services. While providing stable housing, as well as a minimum income is definitely a good start; this must be followed up with personalised support, developed in accordance with the needs and desires of the service user. Therefore, at no point should the interests of the service take precedence over the person and their needs. Furthermore, service provision must also respect individuals' own preferences, because institutionalised culture can occur even within the community when someone does not have the opportunity to make informed choices. Services that impose restraints, or compulsory treatment, often discourage people from using the services and may thus contribute to homelessness. Self-help or peer support groups of (ex-)users of psychiatry, and 'runaway houses'[6] should all be acknowledged as parts of a wide spectrum of services available in the community.

The deinstitutionalisation process can be long and onerous, requiring careful planning and able decision-making. But, in the end, it all goes back to what kind of Europe we want to live in. Are we happy to live in a European Union where at least 300,000 people live locked away from society? Do we want to live in a place where human rights abuses are inflicted on the most vulnerable in society? If the answer is no, then, however complicated deinstitutionalisation and the development of community services might be, they are well worth it.

6 A 'Runaway-house' (or "Weglaufhaus' in German) is a place for people who want to get out of 'revolving-door' psychiatry and have decided that they want to live without psychiatric diagnoses and psychiatric drugs.

An Art-Based Open Studio: A Safe Haven

By **Linda den Otter**,[1] *Art Therapist, Stichting BYOU,*[2] *Non-Profit Drop-In Centre, Zwolle, The Netherlands*

Stefan has had enough of life. He doesn't want help. Then his friend takes him along to a drop-in centre. People don't look at him funny there. Stefan gets the impression that they accept him just the way he is. A few weeks later Stefan takes part in 'creative expression'. He slowly opens up. And discovers that he has a new vocation: life artist. Taught by the therapist who stood by him.

This is just a passing glance at Stefan's life. It is however the essence of the added value of art therapy. In the Netherlands, Stichting BYOU is a front-runner in the field. In the United States they have made much more progress. Also with scientific underpinning. Starting with Stichting BYOU I conducted a qualitative needs study on how art therapy can be accommodated in a drop-in centre.

First I discuss the background and context, and then I go deeper into my research and conclusions. Finally I make a particular appeal to stand by young people and welcome them to the profession assigned to every one of us: to be a life artist.

BACKGROUND AND CONTEXT

Within the present care system around street youth there is a lack of care structures that connect seamlessly with this target group. Street youth are difficult to 'catch', and the bar to current regular mental health care seems set too high. At the moment there is no joined-up working in the system that receives these young people. This means they end up being pushed from pillar to post. As a result, these young people often become unable to express themselves. Research shows what young people find important in the provision of care. They state their requirements. Safety, and confidence in a regular support person are at the top of the list. Beside the fact that 70% of young people are depressed and at least 40% have attempted suicide at some point in the past prior to leaving their own homes and families, there are many psychosocial problems such as low self-esteem and reduced self-confidence.

The most recent research conducted in 4 countries reveals that by strengthening resilience and the realising of one's own qualities, many mental health problems fade into the background (Deth, A., Doorn, L. Van, 2009). In the Netherlands and Europe no specific form of treatment has as yet been developed for homeless people. A national survey is currently underway with the objective of developing a specific method of guidance for street youth (Foothold method). The focus lies on offering recovery and working towards the realisation of one's own inner strengths (resilience) and on using these to work towards the desired quality of life (Wolf, J, 2009).

In America, however, treatment programmes have been developed catering to the specific needs of young and adult homeless persons, with as their aim - among other things - the "strengthening of resilience". "Art therapy" is mostly used as a basis for the recovery, restoration and rebuilding of the strengths of homeless people. Professional therapy is offered both in a "community art-based open studio" (drop-in centre for homeless people where everyone is welcome) and in closed group sessions. At the present moment I am working in a drop-in centre for homeless youth. In the Netherlands no professional therapy is offered in drop-in centres for homeless youth. The required care is still expected to come from the regular mental health care system. However, that system has to contend with a waiting list of approximately 3-6 months. And that means that the threshold is too high, besides the necessary diagnosis, for them to follow treatment. The situation of homeless people is traumatic, plus the fact that there may also be (many) other traumas that have a negative effect on health. With existing mental problems, reintegration into society (living autonomously again, working) is often doomed to failure, which again has a negative effect on self-confidence and self-image. Offering mental health care in a low-threshold, attractive manner therefore appears very necessary.

Since September 2011, I have been working as a creative therapist (first in the form of practical teaching, then from January 2012 in full-time service) in a drop-in centre. Stichting BYOU is a neutral organisation subsidised by the local authority in Zwolle. Stichting BYOU has been given the task of receiving young people and looking after them on the basis of their needs and then offering a daytime activities programme to help young persons to take care of themselves in the local environment (self-reliance). To flesh out these objectives, Stichting BYOU implemented a specific guidance method for social relief. This method, known as Herstelwerk ("Recovery"), is the expectant "mother" of the specific guidance method for young homeless persons (Foothold method). As described, this method sets out in a phased move towards one's desired quality of life. From a period of recovery one moves on to a period of realisation of his/her own identity, mending cracks and removing obstacles standing in the way of self-reliance. In the Netherlands, no art therapy is as yet available in a drop-in centre, although this method is being applied. Referral to mental health care facilities to work on the formation of identity and healing wounds seems to be the only logical step. As already mentioned, this step is not an easy one for homeless youth to take.

Offering mental health care in a low-threshold, attractive manner [...] appears very necessary.

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Is there any difference in a person's cultural needs when it comes to survival in the street culture? Why is it that art therapy connects so well in America when it comes to recovery while the Netherlands and large parts of Europe seem to have closed off the way to the creative process and appear to give higher priority to cognitive processes?

Thus my question is: how can I deploy creative therapy (art therapy) in the Netherlands in a connected, low-threshold, attractive manner in a drop-in centre that must meet the needs of young people?

RESEARCH

The key question of the research is: What needs of homeless youth visiting a drop-in centre are in the foreground, and in what way can creative therapy fill the gap between the need for mental health care for these young people and the current offer of the regular mental health care system?

As a conclusion I have been able to establish that, what homeless youth need, first of all, is for the basic necessities of life, such as a secure home environment, preferably a home of their own, food and money, to be present. Once these are provided they seem to be 'satisfied'. Young persons then incline more towards the shaping of other life-events, such as looking for the right education and finding a job.

However, homeless youth struggle with very diverse mental health problems. We can speak of trauma during the years before their leaving home. Experiencing the situation of being homeless is another trauma. Young people seem to want to camouflage these problems. They prefer risk behaviours and addictive substances to feeling the inner wound. The cultural context of homeless youth influences the manifestation of these symptoms of trauma-related problems.

"Acting out" would seem to be the answer to an inwardly felt question. The masking of symptoms means that problems are not always recognised by the subject or by care-givers. Then there is also the big question as to whether this can be expected at all. Recognition of these symptoms may, however, be a matter of life and death. Yet there is a problem when young people are open to working on their mental disorders. The current regular mental health care institution seems to be the designated care-giver; however, given the fact that there is an enormous waiting list, young people experience a threshold that is too high to be able to receive care from that quarter. Young people cannot satisfy the expectations and demands for treatment in a regular mental health care institution, plus the fact that the setting is unsuitable and there is insufficient leeway for working on internal problems. Young people make their conditions clear before they can and will work on their mental problems. Here it is mainly the case of an environment where there is room for one's own autonomy, keeping one's own agenda, choice of possibilities, persons with whom they can form a relationship (rather than persons they will see just 3 times and in the position of "judgment"/examination).

The drop-in centre offers a space that dovetails with the "street culture" and cultural context in which young people find themselves. Offering mental health care in this context seems to readily satisfy the conditions set by young people. There is little if indeed any experience of a threshold. Plus the fact that mental health care is present exactly when it is needed means that young people have the feeling that they are in charge, keeping to their own "agenda" and, thus, following their own lives. Having a choice meets their need for autonomy.

ART-BASED OPEN STUDIO

An art-based open studio in which young people are welcome at the moment when they themselves make the choice is also a factor here. The fact that there is a practitioner with a casual "laid-back" attitude and who listens, first and foremost, inclines young people to make use of this offer. Building a relationship is absolutely essential in this respect. Since the treatment-provider is a familiar face in a drop-in centre, a relationship may also come about in other ways. For instance, meeting in alternative settings (smoking, walking, drinking coffee, music and making art).

From a survey (Otter, L. Den, Stichting BYOU) conducted among homeless youth, it may be concluded that the study of the literature confirms what the survey among young homeless persons brought to light. It is interesting to note that various young persons have asked for individual therapy while elsewhere they had been thought of as "therapy-shy". The art-based open studio seems to meet the specific needs of young people. Not playing the therapist but appearing as an equal, seeing the young person as a fellow artist, allows for contact on an equal footing. Giving a choice between possibilities in materials and techniques allows the young person to start his/her own process and discover his/her individuality.

HIGH CORRELATION BETWEEN REDUCTION OF HEALTH PROBLEMS, POSITIVE LIFE-EVENTS AND EXPRESSION IN ARTISTIC MEDIA

Youth naturally need to express themselves in art and music. They like to make symbols; young people will respond more to creative forms as "language" rather than to "speech" as language. Young people are enthusiastic about art, dance and music, and many young people gravitate towards artistic expression (think, for example, of rap music, beatboxing, graffiti art). This means that they find mental help using these forms of artistic expression attractive, and young people make longer use of mental health care.

The strengthening of one's own resources (resilience) appears to be a successful approach when dealing with mental health problems. One of the pillars of resilience is creativity.

Research has shown that creativity is not only a pillar but, most of all, THE FOUNDATION of the strengthening of resilience. People who are creatively active are, for example, more autonomous and self-accepting, thus increasing their self-esteem and self-confidence. Participative observation has shown that working with creative media makes young people stronger in who they are. They become more themselves, become more aware of themselves and find the courage to take steps in their lives (self-reliance). Research into the relation between creative activity and the strengthening of resilience among homeless adolescents (Prescott, M., 2008) reveals that a correlation between creative activity and an increase in positive life events. Of the 212 young persons regularly participating in an art studio in a drop-in centre, in each case 15 times or more, 48% found a job, 44% returned to education and 52% were given a house because they had acquired the necessary skills. Drug use was reduced or stopped completely and social skills were increased.

HUMAN VISION OF THE PROFESSIONAL "EVERYONE FEELS SOME SORT OF "HOMELESSNESS" INSIDE"

An art-like approach is a good fit here. This involves a certain human vision that leads to a vision of action which must be internalised in a person. This delivers the authenticity of being human necessary for building up a relationship with a young person. Starting from the fact that "homelessness is lurking in the soul of everyone" and everyone is caught up in his or her own "life struggle" means that you drop the "protection" of your function as a therapist. What young people want to know is "where to get what" as far as help is concerned. The word "therapy" need not be avoided; what matters more is who you are as a person. Clarity of role is therefore important, but manner is paramount.

It is about working from the here and now, by being open to the needs of young people in "the present moment". It is about abandoning diagnoses in favour of demand-driven work. This obviously requires courage on the part of the therapist. After all, this requires a high degree of flexibility and letting go of "academic" models that lay down rules on "how to handle disorders" by recourse to "methods". Stepping out of the role of therapist in favour of equality in contact and jointly assuming the role of "life artist" form the right basis for adapting your knowledge as a professional therapist. Precisely the knowledge of the effect of materials, the knowledge of psychopathology, symbolism, metaphor, etc. allows the therapist to identify problems, sometimes even before the young person can see them or gives them his or her own interpretation. However, subjective experience need not always be placed in the foreground. Not coming across as a "magic-man" is very important to these young people, who no longer know who and what they can trust.

As a professional therapist you are important for creating the favourable conditions that young persons need in order to be able to express themselves. Facilitation and anticipation of the correct environment. The professional therapist as "monitor", as "guard", as present "witness", as "holding the container" means that the young person feels safe and can finally express himself or herself naturally. From "acting out" to "acting inside".

"Attending to the other by trying to stand by or support the other when he or she is in the world and living his or her life", that is the meaning of the word *therapeia*, an ancient Greek word.

TRUE FACE

Offering mental health care that connects with the needs of young persons, namely in a drop-in centre, through artistic expression, can avoid situations whereby concealed mental problems remain hidden behind the mask because young persons experience the thresholds as too high for turning to regular mental health institutions. Creative therapy can bridge the gap between young persons' demands and needs and the conditions that they set for accepting treatment.

DOWN-TO-EARTH

The request of homeless and street people is quite simple but at the same time of vital importance: forget all your stigmas, take off your professional masks, forget your prejudices, do not try to prove yourself by thinking in terms of "solutions", of what serves the makeshift quick fix FOR the young persons' needs, and your own need to "score" as a good counsellor. But listen... pay close attention, exactly to what is unsaid. Unmask yourself... because that way we get to see each other as we really are. We are all following the path of our own lives. As life artists, let us all connect with each other in, and through, the creative process.

The word "therapy" need not be avoided; what matters more is who you are as a person. Clarity of role is therefore important, but manner is paramount.

The Life of PIE[1]

By **Peter Cockersell**,[2] *Director Health and Recovery, St Mungo's, UK*

Homelessness is stressful. Imagine for a moment that wherever you call home – your apartment or house, your parents/boyfriend/girlfriend/family/children – just weren't there when you got home from work tonight...It's a terrible thought. Then imagine you've got nobody else to turn to, and nowhere else to go. Which street corner or doorway would you choose for tonight? Or would you just walk round and round until you were too tired to walk round any more?

Homelessness is stressful, and distressing. That is often compounded by people being quite negative or aggressive towards homeless people, so people often experience neglect and at worst hostility from complete strangers. That makes it quite difficult to feel good about yourself. As one rough sleeper said to me: 'I sit among the rubbish bags all day, and the only difference between me and the rubbish bags is that someone comes to collect the bags every day'. And of course it's not very healthy, living on the street, not getting enough food, getting cold, or wet, not being able to wash or change, wearing the same shoes day and night (they might get stolen), week after week. In one first stage hostel we surveyed, the average number of treatable but untreated health conditions was 8, and one man had 14. It's hard to feel 'motivated' when you're sick. It might make you want to get drunk, but then they say it's your own fault you're homeless, because you're 'a drinker'. You might take drugs to ease the discomfort and pain, and to relieve the tedium of living on the streets, but then it's even harder to get a place because you're an active drug-taker.

Of course, all this feels a lot worse – and triggers memories of past abuse and neglect - if you already come from an abusive background, and/or institutional care, and/or have mental health problems, and/or (commonly among our clients) all three...

Then someone comes along from a homelessness agency and says that if you'll just trust them, then they'll let you into their project where, alongside 20 or 30 or 50 or more other damaged people, you will have the opportunity to get housed and helped, as long as you obey their rules. The longer you've been on the streets, and the more you've been neglected and abused, the harder it becomes to take up such an offer. After all, your experience is that those who were supposed to love and care for you mistreated you, hurt you, and ultimately put you on the street. And you know some of the people in the hostel, and they're dangerous. So you say 'No, I'm staying here'. And you're then classified as 'hard to engage'.

People who work with homeless people, whether paid staff or volunteers, and those who manage and fund homelessness services, by and large do so because they want to help; they want to help people find housing, get healthy, find work or training, make or restore relationships – in short, they want to help homeless people change their lives. As we all know, that's not always easy: their help is sometimes rejected or abused. And sometimes staff or volunteers become frustrated because of this, resentful, or disillusioned, or they divide the homeless people they work with into 'worthy' of help – those who cooperate and engage – and 'unworthy', those who seem to undermine all the best efforts to help them.

Change is difficult. If you've ever tried giving up something really habitual – some mannerism or set of words, or a particular way of eating such as 'snacking' – that's hard. If you've given up an addiction – smoking for example – that's often really difficult. If your life is unsafe and uncertain, then change is even more difficult. However, our clients – homeless people and rough sleepers – are a brilliant example of how people can be enormously courageous and can really transform themselves. I worked with one man who came in after 28 years on the street; I met him a few years later and he was still in his flat and he had a job as well, which he really enjoyed, in a street market. People can and do change.

PIEs – Psychologically Informed Environments – are an attempt to support staff and clients in this change-making process. They use the insights of relational, social and environmental psychology to provide staff and clients with a clearer framework and a better understanding of just what change involves, and of why people might be behaving as they are, and of how different ways of interacting with each other might either enable change or disable it: how our interactions can be either creative or destructive, empowering or disempowering.

The concept of Psychologically Informed Environments has its roots in the therapeutic community movement, but is distinct from it. At St Mungo's we have implemented the concept in a range of situations where we work with homeless people, including street outreach, day centres, hostels, and long-term supported accommodation. We have used it with various client groups as well: with people with severe and enduring mental health conditions such as schizophrenia, with people with so-called dual diagnosis,[3] with drug-dependent sex workers, and with rough sleepers. There are five key factors –

- Social spaces
- Managing relationships
- Reflective practice
- Psychological framework
- Evaluation

1 For the full guidance on Psychologically Informed Environments see www.homelesshealthcare.org.uk

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3 Dual diagnosis is the term used to describe patients with both severe mental illness (mainly psychotic disorders) and problematic drug and/or alcohol use.

PIEs also require commitment from the senior staff to make them happen, and a culture of client participation to make them really flourish.

Social spaces are simply spaces which encourage positive social interaction, and which break down hierarchical power relationships. This doesn't necessarily mean expensive building programmes: it might mean removing barriers or glass screens that separate staff and client, or removing all the institutional behavioural signs. In practice, a simple and yet very effective process for creating the social space is to involve clients in their development or refurbishment. A day centre in Verona, Italy, for example, asked its clients and a group of design students to design the space, and all the furniture and signage and so on: the result is a warm, welcoming, embracing and encouraging space – and a positive experience for the clients (and the students). In St Mungo's we have taken the opportunity of major building works on some of our hostels to get the clients and architects sitting down together to plan something that really works for homeless people. On the other end of the scale, it can mean just redecorating or refurnishing a space in a way that includes, and doesn't reinforce images of powerlessness and control.

For me, *managing relationships* is key to the whole concept. It is also intrinsic to the benefit that all those involved can derive from working in a Psychologically Informed Environment. We all grow through positive relationships, yet often staff and volunteers don't actually think about the relationships they are having or how they do them. Our clients say overwhelmingly that there is at least one important relationship in the process of them moving beyond homelessness. Relationships are a very powerful tool for initiating and supporting change. In PIEs, the aim is to better understand and use relationships for positive change. This requires staff to have some basic understanding of e.g. Attachment Theory or Cycle of Change, and of some techniques of managing interactions such as e.g. Motivational Interviewing, or Active Listening.

We are asking our clients to change and to learn. It is important that we do so too, if we are to create an environment in which learning and change can flourish. It is also important that staff have a social space in which to think through and process some of the difficult emotional, psychological and practical issues that working with people with damaging experiences can bring up for them. A way of doing this is through *reflective practice* groups. At St Mungo's we hold team reflective practice groups either fortnightly or monthly in all our PIEs, with facilitation by a qualified and experienced Psychotherapist. We are about to roll this out across all our operational staff.

We work within a psychodynamic framework. It is important to hold a *psychological framework* because it provides the theory and evidence for understanding some of the complex interactions between people, and between people and their environments. We are not making this up! It's evidence-based. We use a psychodynamic framework because relational psychodynamics has the best evidence base in real-world practice of working with homeless people, in clinical studies and research in work with borderline personality disorder, and has the most comprehensive theoretical framework, and is most aligned with the evidence of neuroscience. Neuroscience demonstrates at a fundamental level the importance of emotional processes and personal relationships in the development of thought and behaviour. St Mungo's also provides access to psychodynamic psychotherapy with fully qualified Psychotherapists for the clients of our PIEs with very positive results in terms of engagement and change. We see this as part of the framework, providing a safe space for clients to come to terms with some of their most difficult experiences. Our Psychotherapists also provide reflective practice for the staff.

Evaluation to me is part of reflective practice: we need to know what effect what we do has in order to do our best, and to do our best for our clients. It is also useful for e.g. funders, as it provides data to show the service is effective, and for researchers, to understand better how people change and move out of homelessness. At St Mungo's we use the Outcomes Star, which is aligned with the Cycle of Change and with some of the fundamental psychological processes underpinning change (or lack of it!).

So let's go back to our homeless person...You've been on the streets for a while, you've been ignored and harassed and looked down on, you're sick and tired (rough sleepers sleep badly), and you're worried about your drug/alcohol intake because you're beginning to feel a bit crazy because sometimes you don't really know quite what you're doing, or remember what you've done. Your settled life has unravelled, and now it feels like you're going to unravel too. You don't trust anyone much. But it's cold and you're hungry and this rather nice outreach worker has been coming to see you for some time really patiently, and so you come in...and you're greeted by someone who used to be a rough sleeper – you may even remember them vaguely – and the place is warm and friendly, you don't have to go to a desk with a screen or to a harshly-lit room and answer lots of questions. Someone asks you how you are, and they introduce themselves, and they ask like they mean it, like they really want to know. They treat you with respect, and offer you things. You can have a meal. You can have a room. Though you still don't want to change anything, so far nobody's told you to, and you like that. You hesitate. You think 'I don't like hostels, I get thrown out for drinking', but the person who welcomed you was, well, like you a few months ago, and the other guy, the member of staff who offered the room, was like a genuine person, you feel, who treated you with care and respect, so, almost despite yourself, you say...'OK, I'll stay tonight'. And the change process has begun.

[I]t can mean just redecorating or refurnishing a space in a way that includes, and doesn't reinforce images of powerlessness and control.

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